STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 00 B. WING	04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

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F0000	This visit was for the Investigation of Complaint IN00106227. Complaint IN00106227 - Substantiated. Federal/state deficiencies related to the allegations are cited at F329, F9999. Survey dates: April 9 & 10, 2012 Facility number: 004732 Provider number: 155752 AIM number: 200808300 Survey team: Vicki Manuwal, RN-TC Bobbie Costigan, RN Census bed type: SNF/NF 38 Total 38 Census payor type: Medicare 01 Medicaid 24 Other 13 Total 38 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 4/16/12 by Suzanne	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Williams, RN			

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F0329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on interview and record review, the facility failed to ensure a resident was free from the administration of an unnecessary medication, which resulted in critical laboratory values requiring extensive inpatient monitoring and medical care. This deficient practice affected 1 of 3 residents reviewed for medications in a sample of 3. Resident # D Findings include:	F0329	The facility will ensure that residents are free of unnecessary drugs. Resident D was transferred to the hospital, received treatment and returned to the facility with normal labs. MAR's have been reviewed by DON for accuracy of Medication Administration. No findings at this time. Pharmacist will review medications at least monthly to identify potential for medication reduction or inappropriateness of medication per diagnosis. All orders for medication will be received with at least one	05/04/2012

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	1. The clinical record for Resident # D was reviewed on 4/9/12 at 1:15 P.M. The resident's diagnoses included, but were not limited to: chronic renal insufficiency, history of urinary tract infection, and acute myocardial infarction. Review of the February 2012, "Nurse's Notes" indicated, "...2/13/12 2:40 P.M. Hematuria (blood in the urine) noted during incontinence care. c/o (complaints of) bladder discomfort. Urine c (with) foul odor noted. MD notified et (and) POA (power of attorney) aware. Awaiting return call from MD....2/14/12 11:25 A.M. New order called in by (Name) for Dr. (name) 1. Triamterene (potassium sparing diuretic) 100 mg (milligrams) TID (three times daily). POA/Daughter notified, pharmacy notified....2/17/12 11:00 A.M. Hematuria (blood in the urine) continues. MD & family aware. Fluids encouraged-poor intake...2/24/12 (2 P.M.) Dr. (Name) in to exam (examine) res (resident). O (no) new orders, progress notes written...." Review of a "Fax" cover sheet received on 4/10/12 at 10:25 A.M., from the Practice Manager of Resident # D's physician's private practice indicated, "...2/13/12 14:57 (2:57 P.M.) (fax confirmation stamp)...To: Dr.		diagnosis to minimize potential of errors. DON or designee will review all new orders at least weekly to ensure that appropriate medication is administered per diagnosis. Medical Director or designee will review orders at least weekly to ensure accuracy of medication administration. Nurses will be inserviced on new protocol for taking orders for medications, ie must have a diagnosis with all medication orders. All findings will be reported to QA at least monthly for 6 months or until problem is considered resolved due to no new findings. Reqeust Paper Compliance.	

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	(Name)...Date 2/13/12...RE: (Resident # D)...is now having hematuria et c/o urinary discomfort et bladder pain. Would you consider ordering...Pyridium for routine administration?..." Further review of the above "Fax" indicated in one handwriting, "...2/14/12 - order given to nurse (Name) Triamterene..." and in a separate handwriting, "...OK 100 g (sic) TID..." with a line drawn toward the bottom of the page to the paragraph written by the facility nurse asking for an order for Pyridium. Review of the "Physician's Telephone Orders" indicated, "...2/14/12 9:15 A.M. 1. Triamterene 100 mg TID po..." The order was signed by the facility nurse receiving the order. The order was signed by the ordering physician, but that signature was undated. Review of a "Progress Note" dated 2/13/12, indicated, "...She (Resident # D) has chronic bacteriuria (bacteria in the urine), now hematuria with pain. Recommend Pyridium...." Review of the February 2012 and March 2012, MAR's (Medication Administration Record), indicated Resident # D received Triamterene 100 mg three times daily at			

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	9:00 A.M., 12:00 P.M., and 5:00 P.M. from 2/16/12 through 2/29/12 and 3/1/12 through 3/6/12, and 3/7/12 excluding the 5:00 P.M. dose. Review of the "Dietary Progress Notes" dated 3/7/12, indicated, "...She developed Bacteriuria and this progressed to hematuria c pain/phy. (physician) note 2/13/12....She was to be on Pyridium per phy. progress notes 2/13/12 but received Dyrenium instead which is a K+ (Potassium) sparing diuretic & she has been receiving 100 mg TID. The DON informed of this today by this writer. Nurse in charge of resident is informing physician. Nurse also notes hematuria has gotten worse. Possibly 2* (secondary) to diuretic use...." Review of the March 2012, "Nurse's Notes" indicated, "...3/7/12 3:30 P.M. MD Dr. (Name) informed of administration of Dyrenium (generic name Triamterene) PO (orally) TID beginning 2/14/12 - New order received to DC (discontinue) Dyrenium et begin Pyridium (analgesic used to treat urinary pain) 100 mg PO TID, BMP (basic metabolic panel - lab test) today....3/7/12 6:00 P.M. Lab notified assigned Nurse via phone of patient critical lab results....Assigned Nurse notified Dr. (Name) immediately at 6:00 P.M. He			

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	gave telephone order to call 911 and to send patient to ER (emergency room) immediately for Renal Failure (sudden loss of the ability of the kidneys to remove waste) & Hyperkalemia (condition caused by abnormally high levels of potassium in the blood)....3/7/12 10:30 P.M. Received report from (Hospital Name) ER Nurse and stated resident will be admitted. Notified DON of status....3/12/12 2:05 P.M....Arrived to facility via (Name) Ambulance...3/14/12 11:00 P.M....CNA started there (sic) rounds when they entered Res. room - Res. not breathing. CNA informed nurse-nurse entered room & discovered Res. not breathing. Res. is a DNR (do not resuscitate)...I instructed CNAs to prepare body...." Resident # D expired on 3/14/12. Review of a BMP dated 3/7/12 at 1626 (4:26 P.M.) indicated, "...BUN (blood urea nitrogen) 100C (critical) 8-23 (normal level), Creatinine 3.06H (high) 0.60-1.10 (normal level), Potassium 7.1C (critical) 3.6-5.2 (normal level)...." Review of a "ER Physician Report" dated 3/7/12, received 4/10/12 at 11:10 A.M. from (Name) Hospital Medical Records Employee # 1 indicated, "...It was later discovered she had been given doses of Dyrenium today instead of the prescribed			

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	Pyridium....The patient is started on IV fluids as well as IV D50W insulin...Diagnostic impression: Hyperkalemia, urinary tract infection...." Review of a "History & Physical Exam" dated 3/7/12, indicated, "...This difficulty began when I took a call from the nurses at her nursing home on 03/07. (3/7/12) They told me that we had ordered Pyridium for her chronic bladder pain but she was given Dyrenium which of course is it's (sic) a potassium sparing diuretic. She had gotten that 3 times a day for several days before this error was corrected....1. This is an elderly female who presents with hyperkalemia and renal failure thought secondary to the use of Dyrenium instead of Pyridium. Potassium is improving. Continue vigorous fluid resuscitation....2. Please note acute renal failure may also be secondary to her chronic bladder problems and she could have obstruction...6. Acute renal failure...." During interview with the Administrator on 4/9/12 at 12:40 P.M., he indicated the facility had caught the mistake of the resident receiving Dyrenium instead of Pyridium. Interview with the DON on 4/9/12 at 12:40 P.M., she indicated Resident # D			

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	died of a massive heart attack. During interview with the Registered Dietician on 4/10/12 at 1:40 P.M., she indicated she is a contracted dietician with the facility. She further indicated she reviewed Resident # D's chart related to weight loss. She indicated she reviewed the MD orders then the progress notes to see why the medication had been changed. She then looked the medication up in the drug book and discovered it was a potassium sparing diuretic and immediately brought it to the attention of the DON. Interview with LPN # 2 on 4/10/12 at 2:15 P.M., she indicated one of her co workers had faxed Resident D's doctor a few days earlier to request Pyridium for the resident. She further indicated they only keep the fax cover sheet until they get a confirmation that the fax has gone through. She further indicated the doctor's nurse called in an order for Triamterene and the nurse had to spell the medication because she (LPN # 2) wasn't familiar with the medication. She further indicated she checked with one of her co workers and that nurse was not familiar with the medication either, so the social worker looked up the medication on the internet.			

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	During interview with the doctor on 4/10/12 at 3:10 P.M., he indicated a staff member at his personal office had called the wrong medication into the facility for Resident # D. He further indicated he is unsure how she got Triamterene out of Pyridium. He indicated he received a fax from the nursing home and wrote on the fax "ok" 100 mg TID with a line drawn to bottom of the fax to "Pyridium". He further indicated when the medication error was found, he ordered labs then sent her to the ER. Interview with the DON on 4/10/12 at 4:00 P.M., indicated when a Physician Progress Note comes over the fax, the reports are given to medical records to file in the appropriate chart. She further indicated it is not standard protocol for the DON or nursing staff to review every progress note. The 2010 Nursing Spectrum Drug Handbook indicated, for Triamterene, "...Potassium-sparing diuretic...FDA Boxed Warning - Abnormal serum potassium elevation may occur, and is more likely in patients with renal impairment or diabetes and in elderly or severely ill patients. As uncorrected hyperkalemia may be fatal, monitor serum potassium levels frequently, especially when dosage is changed or patient has an			

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	illness that may influence renal function...." This federal tag relates to complaint IN00106227. 3.1-48(a)(4) 3.1-48(a)(6)			

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F9999	STATE FINDING: The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents, including, but not limited to, any: (A) epidemic outbreaks; (B) poisonings; (C) fires; or (D) major accidents. If the department cannot be reached, such as on holidays or weekends, a call shall be made to the emergency telephone number (317) 383-6144) of the division. (2) Promptly arranging for: (A) medical; (B) dental; (C) podiatry; or (D) nursing; care or other health care services as prescribed by the attending physician. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring that the facility maintains, on	F9999	The facility will ensure that unusal occurrences or other required incidents will be reported to the State per requirements. All incidents have been reviewed by the Management Team to ensure proper reporting protocol. No findings at this time. All incidents not reported will be reviewed by the QA Team at least monthly to ensure proper reporting per requirement. Request Paper Compliance.	05/04/2012

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	the premises, time schedules and an accurate record of actual time worked that indicates the: (A) employees' full names; and (B) dates and hours worked during the past twelve (12) months. This information shall be furnished to the division staff upon request. (5) Maintaining a copy of this article and making it available to all personnel and the residents. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to report to ISDH (Indiana State Department of Health) of an unusual occurrence of a resident receiving the wrong medication for three weeks, resulting in critical laboratory values and hospitalization for treatment, for 1 of 3 residents reviewed for unusual occurrences in a sample of 3. Resident # D Findings include: 1. The clinical record for Resident # D			

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	was reviewed on 4/9/12 at 1:15 P.M. The resident's diagnoses included, but were not limited to: chronic renal insufficiency, history of urinary tract infection, and acute myocardial infarction. Review of the "Physician's Telephone Orders" indicated, "...2/14/12 9:15 A.M. 1. Triamterene (Potassium-sparing diuretic) 100 mg TID po..." The order was signed by the facility nurse receiving the order. Review of a physician's "Progress Note" dated 2/13/12, indicated, "...She (Resident # D) has chronic bacteriuria (bacteria in the urine), now hematuria with pain. Recommend Pyridium (urinary analgesic)...." Review of the February 2012 and March 2012, MARs (Medication Administration Record), indicated Resident # D received Triamterene 100 mg three times daily at 9:00 A.M., 12:00 P.M., and 5:00 P.M. from 2/16/12 through 2/29/12 and 3/1/12 through 3/6/12, and 3/7/12 excluding the 5:00 P.M. dose. Review of the March 2012, "Nurse's Notes" indicated, "...3/7/12 3:30 P.M. MD Dr. (Name) informed of administration of Dyrenium (generic name Triamterene) PO (orally) TID			

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	beginning 2/14/12 - New order received to DC (discontinue) Dyrenium et begin Pyridium (analgesic used to treat urinary pain) 100 mg PO TID, BMP (basic metabolic panel - lab test) today....3/7/12 6:00 P.M. Lab notified assigned Nurse via phone of patient critical lab results....Assigned Nurse notified Dr. (Name) immediately at 6:00 P.M. He gave telephone order to call 911 and to send patient to ER (emergency room) immediately for Renal Failure (sudden loss of the ability of the kidneys to remove waste) & Hyperkalemia (condition caused by abnormally high levels of potassium in the blood)....3/7/12 10:30 P.M. Received report from (Hospital Name) ER Nurse and stated resident will be admitted...." During interview with the doctor on 4/10/12 at 3:10 P.M., he indicated a staff member at his personal office had called the wrong medication into the facility for Resident # D. He further indicated he is unsure how she got Triamterene out of Pyridium. During interview with the DON on 4/10/12 at 4:00 P.M., she indicated she did not report this incident to the state, because it really wasn't a medication error on their part because they administered the medication that was called in. She			

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	further indicated she had discussed it with the Administrator; however, they did not feel it needed to be reported because it was not their mistake. This state finding relates to complaint IN00106227. 3.1-13(g)			